Illinois Department of Public Aid

201 South Grand Avenue East
Springfield, Illinois 62763-0001

Telephone: (217) 782-1200
TTY: (800) 526-5812

George H. Ryan, Governor
Ann Patla, Director

March 30, 2000

The Honorable Donna E. Shalala, Secretary
United States Department of Health and Human Services
c/o Cheryl Harris, Associate Regional Administrator
Health Care Financing Administration
Region V
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Dear Madam Secretary:

I am pleased to submit Illinois' evaluation of our Children's Health Insurance Plan entitled KidCare. This document combines both the FFY 1999 Annual Report and State Evaluation required in Section 2108 of Title XXI of the Social Security Act. The document follows the nationally adopted template designed by the National Academy for State Health Policy.

Illinois KidCare has successfully expanded health benefit coverage to over 95,000 children and pregnant women. We look forward to continued growth in coverage through the coming year.

As directed, two hard copies are enclosed. This document is also being submitted electronically.

Please let me know if you need additional information or clarifications. We look forward to seeing the summary document.

Sincerely,

/s/

Ann Patla, Dr.HL
Director

FRAMEWORK FOR STATE EVALUATION OF CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

(Developed by States, for States to meet requirements under Section 2108(b) of the Social Security Act)

State/Territory: **ILLINOIS**
(Name of State/Territory)

The following State Evaluation is submitted in compliance with Title XXI of the Social Security Act (Section 2108(b)).

/s/
(Signature of Agency Head)

Date: March 30, 2000

Reporting Period: Combined FFY'99 Annual Report and March 2000 Evaluation

Contact Person/Title: Matt Powers, Administrator, Division of Medical Programs

Address: 201 South Grand Avenue East, Springfield, IL 62763-0001

Phone: 217-782-2570 Fax: 217-782-5672

Email: aidd2062@mail.idpa.state.il.us

INTRODUCTION

Illinois has created a continuum of health benefits coverage plans for low-income children in the State. The plans are collectively called KidCare. They are funded by Illinois general revenue funds and Titles XIX and XXI of the Social Security Act.

Illinois KidCare has successfully expanded health benefits coverage to over 95,000 children and pregnant women. As the best measure of success is the number of children enrolled in the program, KidCare is well underway.

This success has resulted largely from the State's emphasis on outreach to find and enroll as many children as possible. Illinois has also greatly simplified the enrollment process. A shorter, full-color application form was developed as a joint application for Medicaid and SCHIP. Families can enroll in KidCare through the mail, much like a private health plan. Application agents in 1,234 locations are available to help families complete applications. Families can also apply in person at local state offices where, for years, families in need have sought assistance. Plans are being made to accept applications over the phone in the near future.

Illinois' children's health benefits continuum includes Medicaid. Prior to the State Child Health Insurance Program (SCHIP), Illinois Medicaid eligibility was set at the federal minimum levels, with no copayments or premiums for children or pregnant women. To coincide with the development of Illinois' SCHIP, Medicaid for children was renamed KidCare Assist. The original Medicaid program for children is referred to as KidCare Assist Base.

Illinois first expanded coverage under SCHIP with an expansion of Medicaid called KidCare Assist Expansion. Effective January 5, 1998, Illinois established a single income eligibility standard of 133% of the federal poverty level (FPL) for children from birth through age 18. At the same time, Illinois increased to 200% FPL the income standard under Medicaid for pregnant women and their babies. This plan is called KidCare Moms and Babies. Individuals enrolled in these plans have no cost sharing requirements.

Illinois launched its separate SCHIP with two plans, KidCare Share and KidCare Premium, providing health benefits to children through age 18 in families with incomes above 133% FPL and at or below 185% FPL. Coverage under these plans was first available October 1, 1998, and is similar to Illinois Medicaid coverage. Families with children enrolled in KidCare Share pay small copayments for services. Families with children enrolled in KidCare Premium pay modest premiums in addition to copayments. American Indian and Alaskan Native families with children enrolled in KidCare have no cost-sharing requirements. As this report was being finalized, federal approval of the State Plan Amendment for these SCHIP plans seemed imminent.

At the same time, Illinois began KidCare Rebate which reimburses families with income above 133% FPL and at or below 185% FPL for all or part of the cost of purchasing private or employer-sponsored health insurance for their children. KidCare Rebate is funded entirely with state funds. The KidCare plans are summarized in the following table:

	KidCare Assist Base	KidCare Assist Expansion	KidCare Moms and Babies	KidCare Share	KidCare Premium	KidCare Rebate
Age	Children 0-18 Pregnant women all ages	0-18	Pregnant women and their babies to age 1	0-18	0-18	0-18
Income (% of FPL)	0-5 ≤133% 6-16 ≤100% 17-18 <50% Preg. Women ≤133%	Above Assist Base through 133%	>133% - ≤200%	>133% - ≤150%	>150% - ≤185%	>133% - ≤185%
Insurance Status	Insured or Uninsured	Insured or Uninsured	Insured or Uninsured	Uninsured	Uninsured	Insured
Medicaid or SCHIP Program	Medicaid	Medicaid SCHIP Expansion	Medicaid	Separate SCHIP	Separate SCHIP	State only
State Plan	Title XIX	Title XXI Submitted 12/31/97 Approved 4-1-98 Title XIX amendment submitted 2/23/98 Approved 4/14/98	Title XIX amendment submitted 2/23/98 Approved 4/14/98	Title XXI amendment submitted 11/9/98	Title XXI amendment submitted 11/9/98	State only
Effective Date	Longstanding	1-5-98	1-5-98	10-1-98	10-1-98	10-1-98
Federal Match Rate	50%	65%	50%	65%	65%	0%
Duration of Financial Eligibility	Children - 12 months [a] Preg. women 60 days postpartum	12 months [a]	Infants to 12 months [a] Preg. women 60 days postpartum	12 months	12 months	12 months

[a] Twelve-month continuous financial eligibility began March 2000 for children in KidCare Assist Base, KidCare Assist Expansion, and KidCare Moms and Babies.

SECTION 1. SUMMARY OF KEY ACCOMPLISHMENTS OF ILLINOIS' SCHIP PROGRAM

KidCare has been successful in providing health benefits coverage to a large number of Illinois children and pregnant women. As of April 1, 2000, 95,381 children and pregnant women are insured because of KidCare. As of January 1, 2000, 81,567 children and pregnant women were enrolled with KidCare. At the same time, Illinois' emphasis on coordinating all KidCare plans has assured that enrollment in KidCare Assist Base has grown as well. Taken all together, KidCare provides health benefits to 752,829 children and pregnant women in Illinois.

KidCare Enrollment		
	01/01/00	**04/01/00**
KidCare Assist Base (enrolled through mail in application)	26,753	37,833
KidCare Assist Expansion	35,981	37,068
KidCare Moms and Babies	4,999	5,038
KidCare Share	5,703	6,202
KidCare Premium	5,336	6,007
KidCare Rebate	2,795	3,233
Subtotal	81,567	95,381
All Other KidCare Assist Base Children	655,452	657,448
Total	737,019	752,829

1.1 What is the estimated baseline number of uncovered low-income children? Is this estimated baseline the same number submitted to HCFA in the 1998 annual report? If not, what estimate did you submit, and why is it different?

The following table shows the baseline data Illinois is using. It is derived from a population survey, detailed in Section 1.1.1, which the State believes to be more accurate for Illinois' populations than the original estimate.

Uninsured Children	
Percent of FPL	**Number of Children**
134% – 185% FPL	43,835
0 – 133% FPL	146,948
TOTAL	190,783

1.1.1 What are the data source(s) and methodology used to make this estimate?

Illinois' original baseline estimate was based on the results of the U.S. Census Bureau's Current Population Survey (1993 – 1996).

The State contracted for an Illinois-specific population survey to develop more reliable estimates of the insurance status of low-income children in Illinois. The survey was specifically designed to complement the structure of Illinois' KidCare plans.

The survey, a dual-frame, mixed-mode design, was structured to allow estimates to be made of the number and distribution of households with children under age 19 in families with adjusted gross income below 250% of the FPL. The in-person component, conducted to mitigate against bias introduced by incomplete telephone penetration and low survey completion rates in urban areas, used household listings to generate a sampling frame and employed a multi-stage stratified sampling technique in the State's most populous county. The telephone component, conducted in all areas outside the most populous county, used standard random digit dialing procedures. A screening instrument was used to select respondents into the study based on income and the presence of children in the family. The main instrument was used to collect data necessary to make estimates of children's insurance status by parents' income.

1.1.2 What is the State's assessment of the reliability of the baseline estimate? What are the limitations of the data or estimation methodology?

The State believes the population survey estimates to be reliable. The limitation of using this alternate methodology lies primarily in its expense.

1.2 How much progress has been made in increasing the number of children with creditable health coverage? How many more children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A))

As indicated in the table on page 3, Illinois has enrolled over 95,000 children and pregnant women.

1.2.1 What are the data source(s) and methodology used to make this estimate?

Administrative data.

1.2.2 What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology?

The State is very confident that 95,381 is a reliable number. The count is taken from State eligibility data.

1.3 What progress has been made to achieve the State's strategic objectives and performance goals for its SCHIP program(s)?

Illinois is pleased with the progress toward its goal. Over 95,000 children and pregnant women have health insurance coverage in Illinois because of KidCare expansions.

In its Title XXI plan, Illinois specified that its assessment of the success of the program implemented under the Plan would be measured by the extent to which children received health benefits coverage as a result of the program. Most of the original performance goals supplied in the Title XXI Plan do not address this specific measure. While they are important to assessing various components of KidCare, they are adjunct to the basic purpose of increasing health benefits coverage of low-income children in Illinois. The State has determined that the program has not been in operation long enough to allow meaningful assessment of objectives other than those addressing enrollment into KidCare. For example, KidCare Share and KidCare Premium have been in operation for about 18 months. Enrollment into the plans grew slowly in the initial months, and few children have actually been enrolled for a full year. That fact, taken together with normal lags in provider billing, has made meaningful analysis of quality or service utilization impossible at this point. Consequently, only enrollment and outreach goals and objectives are addressed in this report.

Table 1.3 summarizes Illinois' strategic objectives, performance goals, performance measures and progress towards meeting goals used to evaluate the effectiveness of KidCare. The table is completed as follows: Column 1 lists Illinois' strategic objectives for the SCHIP program. Column 2 lists the performance goals for each strategic objective. Column 3 indicates, for each performance goal, how performance is being measured, and progress towards meeting the goal.

Table 1.3		
(1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress
Extend health benefits coverage among Medicaid eligible but not enrolled children. [a]	By January 1, 2000, increase the percentage of children enrolled in the program who are eligible at the Medicaid standard in effect on March 31, 1997. Enroll one-third of the number of children identified by the Population Survey as eligible but not enrolled in KidCare Assist Base.	Data Sources: The population survey and enrollment data. Methodology: Numerator: Children enrolled in KidCare Assist Base through ma in application - 26,753 (for January 2000) Denominator: Number of uninsured children eligible for KidCare Assist Base and not enrolled (from population survey data) - 106,081 Equals 25% Discussion: Although slightly short of the goal of enrolling one-thi of unenrolled eligible KidCare Assist Base children, Illinois has been very successful in enrolling uninsured children eligible for KidCare Assist. Enrollment records are kept for at least two years Based on this data, nearly two-thirds of the children enrolled into KidCare Assist Base were not previously on the program. This indicates that KidCare outreach and enrollment strategies are reaching families that Medicaid had not previously reached. Illinois meets this goal when taking data for enrollments effective April 2000 into account. April enrollment in KidCare Assist Base through the mail-in application is 37,833. When divided by the population survey denominator, the value is nearly 36% -- over one-third of those children identified by the Population Survey.

[a] The text of this objective has been changed to clarify the target group. The actual objective has not changed.

Table 1.3		
(1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress
Extend health benefits coverage to optional targeted, low income children.	By January 2000, enroll in Title XXI at least 50 percent of the estimated 40,867 optional targeted low income children with family income above the 3/31/97 Medicaid standard but at or below 133% of the FPL.[a]	Data Source: The population survey and enrollment data Methodology: The denominator is the total number of uninsured children as documented by the population survey. The numerator is the differential (increase) in the base population from the time of the survey to January 2000. February 1999 = 24,621 January 2000 = 35,981 Population Survey of uninsured kids = 40,867 Hence: (35,981 – 24,621)/40,867 28% Discussion: Although Illinois did not enroll 50% of the childre eligible for the KidCare Assist Expansion program, 28% is a significant accomplishment. In addition, Illinois continues to see progress in enrollments. This number has already increased to 37,068 by April 2000, raising the percentage to 30%.

[a] The estimated 40,867 children with income above the 3/31/97 income standard and at or below 133% FPL is slightly different from the estimate of 40,440 reported in Illinois' Title XXI State Plan.

Table 1.3		
(1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress
Extend health benefits coverage to targeted, low-income children. [a]	By January 2000, enroll in KidCare at least 50 % of the children whose family income is above 133% of the FPL and at or below 185% of the FPL (population survey estimate = 43,835.) [b]	Data Source: The population survey and enrollment data Methodology: The denominator is the total number of uninsured children as documented by the population survey The numerator is the differential (increase) in base population from the time of the survey to January 2000. February 1999 = 1,508 January 2000 = 11,039 Population Survey of uninsured kids = 43,835 Hence: (11,039 – 1,508)/43,835 22% Discussion: Although Illinois did not enroll 50% of the children eligible for KidCare Share and Premium, 22% represents significant growth. Taking into consideration that many of the enrollees in KidCare Rebate might not have been enrolled in an insurance plan at the time of the survey, the percentage enrolled toward the goal rises to over 27% for January 2000 and to 31% for April 2000 enrollments.

[a] The text of this strategic objective has been changed to clarify the target group. The actual objective has not changed.

[b] The performance goal has been changed to clarify that the target population includes only children who are not eligible for KidCare Assist Base, KidCare Assist Expansion or KidCare Moms and Babies (Medicaid).

Table 1.3		
(1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress
Implement a statewide outreach and public awareness campaign regarding the importance of preventive and primary care for well-children and the availability of health benefits coverage through Title XXI.	Launch a statewide outreach campaign through the coordinated efforts of the Illinois Departments of Public Aid and Human Services.	Data Sources: Department information on initiatives. Methodology: Tracking of implemented initiatives and outcomes. **Progress Summary**: Illinois has implemented a very successful, multi-pronged approach to outreach. Through a variety of strategies, Illinois, with its partners, has spread the word about KidCare which has resulted in the enrollment of over 95,000 children and pregnant women. General outreach strategies included: the expansion KidCare Application Agents (KCAAs) to include more provider types; $50 technical assistance payments to KCAAs; colorful and vivid promotional materials; an a purpose toll-free KidCare hotline; collaboration with th Covering Kids Illinois Coalition, funded by the Robert Wood Johnson foundation; radio and television ads; and bus and train advertisements. Other strategies included: $1.6 million in funding to 2 organizations for specialized outreach to hard to reac populations including immigrants, non-English speaking populations, and rural families; targeted outreach to Hispanics and African Americans; targete outreach to rural families; employer outreach strategies; school-based outreach; outreach efforts w faith-based organizations and health care providers.

Table 1.3		
(1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress
Implement a statewide outreach and public awareness campaign regarding the importance of preventive and primary care for well-children and the availability of health benefits coverage through Title XXI.	Increase the number of community-based sites certified by DPA to accept eligibility applications for forwarding to and eligibility determination by the Central Statewide KidCare Unit.	In December 1998, Illinois had 333 outstation sites. In 199 Illinois began working with these providers and many more to make them KidCare Application Agents (KCAAs). The duties of KCAAs were the same as outstation providers – t explain KidCare and help families complete applications fo the program. KCAAs mail completed applications to the KidCare Unit where program eligibility is determined. One difference between KCAAs and outstation providers is that since April 12, 1999, KCAAs receive $50 from the State fo each complete application that results in a new enrollment Illinois has expanded the number of KCAAs by adding new categories of providers. In addition to the Disproportionate Share Hospitals (DSH) and Federally Qualified Health Centers that were outstation providers, the following types providers were added as KCAAs. • Other non-DSH hospitals • Local health departments • WIC sites • Family case management agencies • Community action programs • Faith based organizations • Physicians or physician groups • Other approved providers • Licensed Insurance brokers Data Sources: KCAA provider information Methodology: Compare number of KCAA provider sites in February 2000 to the number in December 1998. December 1998 – 333 sites February 2000 – 1,234 sites **Progress Summary**: Illinois has been very successful in expanding the numbers of providers participating as KCAA

SECTION 2. BACKGROUND

In addition to the existing KidCare Assist Base, and with federal and state resources, Illinois has created five KidCare plans. Illinois is also using state dollars to provide KidCare health benefits coverage to legal resident children who are barred from federal programs.

2.1 How are Title XXI funds being used in your State?

2.1.1a The following programs are funded through Title XXI.

X Providing expanded eligibility under the State's Medicaid plan (Medicaid SCHIP expansion)

Name of program: KidCare Assist Expansion

Date enrollment began (i.e., when children first became eligible to receive services): January 5, 1998

X Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (State-designed SCHIP program)

Name of program: KidCare Share and KidCare Premium

Date enrollment began (i.e., when children first became eligible to receive services): October 1, 1998

2.1.1b The following program is funded through Title XIX.

X Other Medicaid expansion to 200% of poverty level for pregnant women and their infants

Name of program: KidCare Moms and Babies

Date enrollment began (i.e., when children first became eligible to receive services): January 5, 1998

2.1.1c The following programs are funded only with state funds. They are not a part of Illinois' Title XXI Plan, but are critical to the Title XXI Plan's success.

X Other Reimbursement to families to help them pay for private or employer-based health insurance premium costs

Name of program: KidCare Rebate

Date enrollment began (i.e., when children first became eligible to receive services): October 1, 1998

__X__ Other Health benefits for legal resident persons barred from federal programs

Name of program: KidCare Assist Base, KidCare Moms and Babies, KidCare Assist Expansion, KidCare Share, KidCare Premium, KidCare Rebate. (Note: KidCare Rebate was not available to these children during the program's first year.)

Date enrollment began (i.e., when children first became eligible to receive services): October 1, 1998

2.2 What environmental factors in your State affect your SCHIP program? (Section 2108(b)(1)(E))

2.2.1 How did pre-existing programs (including Medicaid) affect the design of your SCHIP program(s)?

Illinois' SCHIP programs were heavily influenced by Illinois' Medicaid program, KidCare Assist. The State's first phase involved a Medicaid SCHIP expansion. The State then moved to establish separate state SCHIP plans. Two of these, KidCare Share and KidCare Premium use the same provider networks, claims processing systems and rates as Medicaid. The benefits they provide are exactly the same as KidCare Assist with two minor exceptions – Home and Community Based Waiver services and abortion services. The State chose this delivery system because it was relatively simple to operationalize and because Illinois Medicaid claims processing system is highly efficient. Illinois created another state-operated program, KidCare Rebate, in response to concerns that families should receive support to take advantage of private or employer-sponsored health insurance. KidCare Rebate does not receive federal match at this time. Illinois determined, nonetheless, that families deserved to have a choice of health plans that were not government operated and that it was inequitable to deny support to families who had already acted prudently to insure their children, despite the fact that they had income between 133% – 185% FPL.

2.2.2 Were any of the preexisting programs "State-only" and if so what has happened to that program?

__X__ No pre-existing programs were "State-only"

_____ One or more pre-existing programs were "State only" Describe current status of program(s): Is it still enrolling children? What is its target group? Was it folded into SCHIP?

2.2.3 Describe changes and trends in the State since implementation of your Title XXI program that "affect the provision of accessible, affordable, quality health insurance and healthcare for children." (Section 2108(b)(1)(E))

__X__ Changes to the Medicaid program

- _[a]_ Presumptive eligibility for children
- _[b]_ Coverage of Supplemental Security Income (SSI) children
- X [c] Provision of continuous coverage (specify number of months 12)
- X Elimination of assets tests
- X Elimination of face-to-face eligibility interviews as the only application method
- X Easing of documentation requirements

[a] Currently under consideration.
[b] Income eligible SSI children were covered by Illinois Medicaid prior to Title XXI implementation.
[c] Illinois implemented continuous coverage for children effective March 2000.

Illinois opted to extend simplifications established for SCHIP, KidCare Share, KidCare Premium and KidCare Rebate, to KidCare Assist and KidCare Moms & Babies to the extent allowable under Title XIX. These changes have increased KidCare Assist Base enrollment. The simplified, joint mail-in application alone has resulted in the enrollment of 37,833 children and pregnant women into KidCare Assist Base.

__X__ Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF (specify) _____

KidCare has been implemented at the same time that the State has been adjusting systems and processes to fully implement welfare reform. Illinois has taken many steps to delink Medicaid from TANF and this work continues. The steps Illinois has taken to integrate SCHIP application processes with Medicaid have significantly contributed to the State's

delinking efforts. Illinois Medicaid, however, covers all families participating in TANF and does not require a separate application for receipt of these benefits.

Data processing changes have been made and instructions issued to staff to ensure that Medicaid is completely delinked from the receipt of TANF. All persons who are Medicaid eligible after the loss of TANF are either authorized a medical extension or changed to a Medicaid-only case. This includes persons who lose TANF due to failure to comply with a work requirement, as well as persons who lose TANF due to income.

Steps have also been taken to make sure that all families who lose TANF due to employment receive a medical extension. In addition, with State funds, the medical extension that is authorized to persons who lose TANF due to receipt of child support has been increased from 4 months to 12 months.

Beginning in March 2000, the State began taking advantage of a federal option that allows the State to give 12 months of continuous Medicaid eligibility to persons under age 19.

KidCare insures more children now than were covered at the end of the AFDC program (June 1997).

_X_ Changes in the private insurance market that could affect affordability of or accessibility to private health insurance

- _X_ Health insurance premium rate increases
- _X_ Legal or regulatory changes related to insurance
- ___ Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market)
- ___ Changes in employee cost-sharing for insurance
- ___ Availability of subsidies for adult coverage
- ___ Other (specify)

The Illinois General Assembly has enacted and the Governor has signed several pieces of legislation in recent years affecting health insurance. Although it is too early to determine the actual impact of these changes on the marketplace, the changes may increase access to care for some low-income children.

Most recently, State legislation creating the Managed Care Reform and Patient Rights Act was adopted. Effective January 1, 2000, this legislation is intended to generally increase access to health care services by expanding availability of specialty care, emergency care, and transitional

care and by creating more liberal grievance / appeals procedures in managed care settings.

Changes have also been made in Illinois law requiring that both HMOs and Accident & Health policies cover: 1) a minimum timeframe for inpatient care for mother and child following a delivery; 2) a newborn from the moment of birth; and 3) children pending adoption or custody pursuant to a court order.

Finally, the Illinois Health Insurance Portability and Accountability Act became effective June 1, 1997. It is intended to generally increase accessibility due to guaranteed issue, guaranteed renewability, portability of coverage, and pre-existing condition reductions for both Accident & Health policies and HMOs.

__X__ Changes in the delivery system

__X__ Changes in extent of managed care penetration (e.g., changes in HMO, IPA, PPO activity)

Though the Illinois Medicaid program has experienced a slight decline in enrollment in the voluntary managed care program from 1998 through January 2000, commercial and private coverage in Illinois provided through HMOs continues its upward trend. According to the Illinois Department of Insurance, approximately 2.4 million Illinoisans were enrolled in an HMO in 1998 (up from less than 2 million in 1995).

The decline in Medicaid managed care enrollment is proportional to the declining TANF base population eligible for the program. The percentage of eligible TANF grant clients choosing managed care has actually stayed fairly constant at over 50 percent.

____ Changes in hospital marketplace (e.g., closure, conversion, merger)

The hospital marketplace has not changed significantly.

____ Development of new health care programs or services for targeted low-income children (specify) _____

____ Changes in the demographic or socioeconomic context

____ Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify) _____

____ Changes in economic circumstances, such as unemployment rate (specify)

Illinois' economic, demographic and socioeconomic indicators have not changed significantly since KidCare began in January 1998.

SECTION 3. PROGRAM DESIGN

Illinois submitted its State Plan for the KidCare Assist Expansion (Medicaid SCHIP Expansion) in December 1997 to cover children in families with income up to 133% FPL. A State Plan Amendment was submitted in November 1998 for KidCare Share and KidCare Premium (separate SCHIP Programs) to cover children from 133% to 185% FPL. Effective January 5, 1998, Illinois amended its Title XIX State Plan to cover pregnant women and their babies up to 200% of the FPL.

3.1 Who is eligible?

3.1.1 The table below describes the standards used to determine eligibility of targeted low-income children for child health assistance under KidCare.

Table 3.1.1

	Medicaid Pre-CHIP: KidCare Assist Base	**Medicaid SCHIP Expansion: KidCare Assist Expansion**	**Medicaid Expansion: KidCare Moms and Babies**	**State-designed SCHIP: KidCare Share**	**State-designed SCHIP: KidCare Premium**	**State-Only Funded: KidCare Rebate**
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide
Age	Children 0-18 Pregnant women all ages	0-18	Pregnant women and their babies to age 1	0-18	0-18	0-18
Income (See the following list of countable income)	0-5 ≤133% 6-16 ≤100% 17-18 ≈ 50% Preg. Women ≤133% FPL	Above Assist through 133% FPL	> 133% ≤ 200% FPL	> 133% ≤ 150% FPL	> 150% ≤ 185% FPL	> 133% ≤ 185% FPL
Resources (including any standards relating to spend downs and disposition of resources)	N/A [a]	N/A [a]	N/A [a]	N/A	N/A	N/A
Residency requirements	Illinois Resident	Illinois Resident	Illinois Resident	Illinois Resident	Illinois Resident	Illinois Resident
Disability status	N/A	N/A	N/A	N/A	N/A	N/A
Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))	N/A	N/A	N/A	Requires 3 months without insurance	Requires 3 months without insurance	Requires insurance

	Medicaid Pre-CHIP: KidCare Assist Base	Medicaid SCHIP Expansion: KidCare Assist Expansion	Medicaid Expansion: KidCare Moms and Babies	State-designed SCHIP: KidCare Share	State-designed SCHIP: KidCare Premium	State-Only Funded: KidCare Rebate
Citizen or legal resident eligible for federal funding	Eligible	Eligible	Eligible	Eligible	Eligible	Eligible
Children who are legal residents but subject to the five year bar for federal programs [b]	Eligible	Eligible	Eligible	Eligible	Eligible	Eligible [c]
Inmate of a public institution	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
Resident of an institution for mental diseases at the time of application	Eligible[d]	Eligible	Eligible[d]	Ineligible	Ineligible	Ineligible

[a] Children in families with income in excess of 185% FPL (other than children under 1 who are covered by KidCare Moms and Babies) can be eligible for KidCare Assist if they spend down to the spend down standard (approximately 45% FPL).

[b] Illinois funds, at total state expense, legal resident children who are barred from federal programs.

[c] These children were not eligible for KidCare Rebate in the beginning of the program.

[d] Pregnant women are eligible only if they are under age 22.

3.1.1.1 For each program, do you use a gross income test or a net income test or both?

Title XIX Child Poverty-related Groups	____	Gross	X [a]	Net	____	Both
Title XXI Medicaid SCHIP Expansion	____	Gross	X [a]	Net	____	Both
Title XXI State-Designed SCHIP Program	____	Gross	X [a]	Net	____	Both
Other Separate State-funded Program	____	Gross	X [a]	Net	____	Both

[a] In determining income eligibility, Illinois starts with gross income, before payroll deductions, and then subtracts several disregards detailed below.

3.1.1.2 What was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately.

Title XIX Poverty-related Groups:
KidCare Assist Base

≤ 133% FPL for children under age 6 and pregnant women
≤ 100% FPL for children aged 6-16
≈ 45% FPL for children aged 17-18

Title XIX Poverty-related groups: **KidCare Moms and Babies**	> 133% and ≤ 200% FPL for pregnant women of all ages and their infants to age 1
Title XXI Medicaid SCHIP Expansion: **KidCare Assist Expansion**	Above Assist Base ≤ 133% FPL for children aged 0-18
Title XXI State-Designed SCHIP Program: **KidCare Share**	> 133% and ≤ 150% FPL for children aged 0-18
Title XXI State-Designed SCHIP Program: **KidCare Premium**	> 150% and ≤ 185% FPL for children aged 0-18
Separate State-funded Program: **KidCare Rebate**	> 133% and ≤ 185% FPL for children aged 0-18

3.1.1.3. Table 3.1.1.3 is completed to show whose income counted when determining eligibility for each program and which household members are counted when determining eligibility? (In households with multiple family units, refer to unit with applicant child). "Y" designates yes, "N" designates no.

Table 3.1.1.3

Family Composition	KidCare Assist Base and KidCare Moms and Babies	KidCare Assist Expansion	KidCare Share	KidCare Premium	KidCare Rebate
Child, siblings, and legally responsible adults living in the household	Y	Y	Y	Y	Y
All relatives living in the household	N	N	N	N	N
All individuals living in the household	N	N	N	N	N
Other (specify)	N [a]	N [a]	Y	Y	Y

[a] Through screen and enroll to determine Medicaid eligibility for a family applying on a mail-in application, stepparent income is considered.

3.1.1.4 How do you define countable income? For each type of income please indicate whether it is counted (C), not counted (NC) or not recorded (NR).

Table 3.1.1.4				
Type of Income	KidCare Assist Base, KidCare Moms & Babies	KidCare Assist Expansion	KidCare Share, KidCare Premium	KidCare Rebate
Earnings				
Earnings of adults	C	C	C	C
Earnings of dependent children	NC	NC	NC	NC
Earnings of students	[a]	[a]	[a]	[a]
Earnings from job placement programs	NC	NC	NC	NC
Earnings from community service programs under Title I of the Nat'l and Community Service Act of 1990	NC	NC	NC	NC
Earnings from volunteer programs under the Domestic Volunteer Service Act of 1973 (e.g., AmeriCorps, Vista)	NC	NC	NC	NC
Education Related Income				
College work-study program income	NC	NC	NC	NC
Assistance from programs administered by the Department of Education	NC	NC	NC	NC
Education loans and awards	[b]	[b]	[b]	[b]
Other Income				
Earned income tax credit (EITC)	NC	NC	NC	NC
Alimony payments received	C	C	C	C
Child support payments received	C	C	C	C
Roomer/boarder income	C	C	C	C
Income from indiv. development accts.	NC	NC	NC	NC
Gifts	[c]	[c]	[c]	[c]
In-kind income	NC	NC	NC	NC
Program Benefits				
Welfare cash benefits (TANF)	NC	NC	NC	NC
SSI cash benefits	NC	NC	NC	NC
Social Security cash benefits	C	C	C	C
Housing subsidies	NC	NC	NC	NC
Foster care cash benefits	NC [d]	NC [d]	NC [d]	NC [d]
Adoption assistance cash benefits	NC [d]	NC [d]	NC [d]	NC [d]
Veterans benefits	C	C	C	C
Emergency or disaster relief benefits	NC	NC	NC	NC
Low income energy assistance pymts.	NC	NC	NC	NC
Native American tribal benefits	NC	NC	NC	NC
Other Types of Income (specify)	[e]	[e]	[e]	[e]

[a] Counted if income is from someone ≥ age 19; not counted if person is < age 19.

[b] Education loans and awards not administered by the Federal Department of Education are counted if not used for items such as tuition and education expenses.

[c] $50 per quarter is not counted.

[d] Independent Living Arrangement payments are counted.

[e] Income is considered in the same manner as Medicaid. This information is available in Illinois' Title XIX State Plan and is summarized in Illinois' FFY 1998 SCHIP Report.

3.1.1.5 The following table indicates *amounts* of disregards and deductions each program uses to arrive at total countable income. (If not applicable, enter "NA".)

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) ____ Yes _X_ No

If yes, please report rules for applicants (initial enrollment).

Table 3.1.1.5

Type of Disregard/Deduction	KidCare Assist Base	KidCare Assist Expansion	KidCare Moms and Babies	KidCare Share and Premium	KidCare Rebate
Earnings	$90	$90	$90	$90	$90
Self-employment expenses [a]	$ actual	$ actual	$ actual	$ actual	$ actual
Alimony payments received	$0	$0	$0	$0	$0
Alimony paid	$ actual	$ actual	$ actual	$ actual	$ actual
Child support payments received	$50	$50	$50	$50	$50
Child support paid	$ actual	$ actual	$ actual	$ actual	$ actual
Child care expenses	$ actual [b]	$ actual [b]	$ actual [b]	$ actual [b]	$ actual [b]
Medical care expenses	$0	$0	$0	$0	$0
Gifts	$0	$0	$0	$0	$0
Other types of disregards/deductions (specify)	N/A	N/A	N/A	N/A	N/A

[a] As defined by state policy.

[b] Up to $175 per child age 2 and older and $200 for children under 2.

3.1.1.6 For each program, do you use an asset or resource test?

Title XIX Poverty-related Groups: KidCare Assist Base and KidCare Moms and Babies	_X_ No__Yes (complete column A in 3.1.1.7)
Title XXI SCHIP Expansion program: KidCare Assist Expansion	_X_ No __Yes (complete column B in 3.1.1.7)
Title XXI State-Designed SCHIP program: KidCare Share and KidCare Premium	_X_ No __Yes (complete column C in 3.1.1.7)
Other State-funded program: KidCare Rebate	_X_ No __Yes (complete column D in 3.1.1.7)

3.1.1.7 How do you treat assets/resources?

Table 3.1.1.7 indicates the countable or allowable level for the asset/resource test for each program and describes the disregard for vehicles. (If not applicable, enter "NA.")

Table 3.1.1.7

Treatment of Assets/Resources	Title XIX Poverty-related Groups: KidCare Assist Base and KidCare Moms and Babies (A)	Title XXI Medicaid SCHIP Expansion: KidCare Assist Expansion (B)	Title XXI State-designed SCHIP Program: KidCare Share and KidCare Premium (C)	Other State-funded Program: KidCare Rebate (D)
Countable or allowable level of asset/resource test	N/A	N/A	N/A	N/A
Treatment of vehicles: Are one or more vehicles disregarded?	N/A	N/A	N/A	N/A
What is the value of the disregard for vehicles?	N/A	N/A	N/A	N/A
When the value exceeds the limit, is the child ineligible ("I") or is the excess applied ("A") to the threshold allowable amount for other assets?	N/A	N/A	N/A	N/A

3.1.1.8 Have any of the eligibility rules changed since September 30, 1999? ___ Yes

X

No

3.1.2 How often is eligibility redetermined?

Table 3.1.2

Redetermination	KidCare Assist Base, KidCare Assist Expansion, and KidCare Moms and Babies	KidCare Share and KidCare Premium	KidCare Rebate
Monthly			
Every six months			

Every twelve months	X	X	X
Other (specify)			

3.1.3 Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))

X Yes Which program(s)? KidCare Share, KidCare Premium and KidCare Rebate

Twelve months continuous eligibility for KidCare Assist Base and KidCare Assist Expansion began in March 2000.

For how long? 12 Months

____ No

3.1.4 Does the SCHIP program provide retroactive eligibility?

X Yes Which program(s)? KidCare Assist Base and KidCare Assist Expansion

How many months look-back? 3

____ No

Although enrollment is prospective, families can request KidCare payment for services received up to two weeks prior to the application date for KidCare Share and KidCare Premium.

3.1.5 Does the SCHIP program have presumptive eligibility?

____ Yes

X No

Illinois conducted a pilot Title XIX presumptive eligibility project in December 1998 and is continuing to explore the use of presumptive eligibility under Title XXI.

3.1.6 Do your Medicaid program and SCHIP program have a joint application?

X Yes Is the joint application used to determine eligibility for other State programs? If yes, specify.

Illinois' KidCare mail-in application is simple and is used only as an application for KidCare plans. Illinois has also made it possible for families to apply in person at state offices located in every county in the State. At the local offices, families can make a single application for TANF, Food Stamps, and a variety of other services as well as KidCare.

3.1.7 Evaluate the strengths and weaknesses of your *eligibility determination* process in increasing creditable health coverage among targeted low-income children.

Illinois implemented a number of initiatives to simplify the process of applying for and determining KidCare eligibility. These have been successful in making application for KidCare easier, in improving the consistency of eligibility determinations, and in enrolling a large number of children and pregnant women. They include:

- **$** eliminating eligibility standards related to assets
- **$** removing verification requirements regarding where and with whom the child lives
- **$** eliminating face-to-face interviews as the only means by which to apply for medical coverage
- **$** redesigning the application to eliminate non-essential questions and greatly simplifying it
- **$** significantly expanding capacity to accept applications by mail
- **$** creating a statewide, central enrollment unit with emphasis on accurate, consistent processing of large volumes of applications
- **$** simplifying verification requirements related to income
- **$** reimbursing KidCare Application Agents who assist families in applying for KidCare with the mail-in application (approval rates for submitted applications have improved significantly, to about 8 out of 10, since implementation of the KCAA program and detailed training).

In addition, applications for all of the KidCare plans can be taken and processed at local state offices in every county, and Illinois is currently planning for applications to be taken by phone

Although income verification is, for some, a challenging part of the application process, it remains an important component of KidCare. In order to ensure program integrity, Illinois has opted to require verification of income at the point of eligibility determination.

3.1.8 Evaluate the strengths and weaknesses of your *eligibility redetermination* process in increasing creditable health coverage among targeted low-income children. How does the redetermination process differ from the initial eligibility determination process?

Illinois has taken steps to streamline its KidCare renewal process. As KidCare Share, Premium and Rebate families come close to the end of their first twelve months of coverage, KidCare sends each family a renewal form to complete. The renewal form has limited information about the covered children printed on it. Families are to indicate changes to the information and attach recent income and other verifications and mail this to the central, statewide enrollment unit, and in some cases to local offices. Families receive the forms with enough time for them to be completed, mailed and processed so that coverage is not interrupted. KidCare contacts families who do not promptly return renewal forms to encourage them to complete the forms.

Plans are being developed to establish a similar process for families with 12 month continuous eligibility through KidCare Assist Base and KidCare Assist Expansion.

3.2 What benefits do children receive and how is the delivery system structured? (Section 2108(b)(1)(B)(vi))

KidCare provides a broad array of benefits through both fee-for-service and voluntary managed care delivery systems. These are described in detail in the following sections.

3.2.1 Benefits

Table 3.2.1 has been completed twice, once for KidCare Share and Premium and once for KidCare Assist and KidCare Moms and Babies, showing which benefits are covered, the extent of cost sharing and benefit limits. Only KidCare Share and KidCare Premium have copayments. Services marked as covered may be subject to prior authorization.

Table 3.2.1 SCHIP Program Type Separate State Program: KidCare Share and KidCare Premium				
	Is Service Covered?	Cost-Sharing (Specify) [a]		
Benefit	(X = yes)	KidCare Share	KidCare Premium	Benefit Limits (Specify)
Inpatient hospital services	X	$2/Admission	$5/Admission	
Emergency hospital services	X	$2/Visit	$5/Visit or $25/Visit	$25 copayment applies only when emergency room is used for non-emergency reason
Outpatient hospital services	X	$2/Visit	$5/Visit	
Physician services	X	$2/Visit	$5/Visit	
Clinic services	X	$2/Visit	$5/Visit	
Prescription drugs	X	$2/Prescription (1-30 day supply)	$3 – Generic or $5 – Brand Name/ Prescription (1-30 day supply)	
Over-the-counter medications	X	$2/Prescription (1-30 day supply)	$3 – Generic or $5 – Brand Name/ Prescription (1-30 day supply)	Covered only when prescribed
Outpatient laboratory and radiology services (hospital based or independent)	X	$0	$0	
Prenatal care	X	$0	$0	
Family planning services	X	$2/Visit	$5/Visit	
Inpatient mental health services	X	$2/Admission	$5/Admission	
Outpatient mental health services	X	$2/Visit	$5/Visit	
Inpatient substance abuse treatment services	X	$2/Admission	$5/Admission	
Residential substance abuse treatment services	X	$2/Admission	$5/Admission	Federal funds are not claimed on the room and board portion
Outpatient substance abuse treatment services	X	$2/Visit	$5/Visit	
Durable medical equipment	X	$0	$0	
Disposable medical supplies	X	$0	$0	
Preventive dental services	X	$0	$0	
Restorative dental services	X	$2/Visit	$5/Visit	
Hearing screening	X	$0	$0	
Hearing aids	X	$0	$0	
Vision screening	X	$0	$0	
Corrective lenses (including eyeglasses)	X	$0	$0	

Developmental assessment				
Immunizations	X	$0	$0	
Well-baby visits	X	$0	$0	
Well-child visits	X	$0	$0	
Physical therapy	X	$0	$0	
Speech therapy	X	$0	$0	
Occupational therapy	X	$0	$0	
Physical rehabilitation services (hospital based)	X	$0	$0	
Podiatric services	X	$2/Visit	$5/Visit	
Chiropractic services	X	$2/Visit	$5/Visit	
Emergency Medical transportation	X	$0	$0	
Home health care services	X	$2/Visit	$5/Visit	
Nursing facility	X	$0	$0	
ICF/MR	X	$0	$0	
Hospice care	X	$0	$0	
Private duty nursing	X	$2/Visit	$5/Visit	
Personal care services				
Habilitative services				
Case management	X	$0	$0	Limited to children diagnosed with mental illness and children under age 3 who are receiving early intervention services
Care coordination				
Non-emergency medical transportation	X	$0	$0	
Other (Specify): Nursing Care Services (Advanced Practice Nurses)	X	$2/Visit	$5/Visit	
Other: Audiology	X	$0	$0	
Other: EPSDT not otherwise listed above	X	$0	$0	
Other: Early Intervention Services	X	$0	$0	
Other: Optometric Services	X	$2/Visit	$5/Visit	

[a] Cost Sharing – No copayments are required for preventive or diagnostic services in any of the categories marked above. The annual copayment maximum per family is $100. Families with children who are American Indians or Alaska Natives do not pay premiums or copayments.

Table 3.2.1 SCHIP Program Type Medicaid and Medicaid SCHIP Expansion			
Benefit	Is Service Covered? (X = yes)	Cost-Sharing (Specify) [a]	Benefit Limits (Specify)
Abortion services	X	$0	Limited per state and federal law.
Inpatient hospital services	X	$3/Day	No copay charged to children, pregnant women or group care recipients
Emergency hospital services	X	$0	
Outpatient hospital services	X	$0	
Physician services	X	$0	
Clinic services	X	$0	
Prescription drugs	X	$0	
Over-the-counter medications	X	$0	Covered only when prescribed
Outpatient laboratory and radiology services (hospital based or independent)	X	$0	
Prenatal care	X	$0	
Family planning services	X	$0	
Inpatient mental health services	X	$0	
Outpatient mental health services	X	$0	
Inpatient substance abuse treatment services	X	$0	
Residential substance abuse treatment services	X	$0	Federal funds are not claimed on the room and board portion
Outpatient substance abuse treatment services	X	$0	
Durable medical equipment	X	$0	
Disposable medical supplies	X	$0	
Preventive dental services	X	$0	
Restorative dental services	X	$0	
Hearing screening	X	$0	
Hearing aids	X	$0	
Vision screening	X	$0	
Corrective lenses (including eyeglasses)	X	$0	
Developmental assessment	X	$0	Available only through home and community based services waiver
Immunizations	X	$0	

Well-baby visits	X	$0	
Well-child visits	X	$0	
Physical therapy	X	$0	
Speech therapy	X	$0	
Occupational therapy	X	$0	
Physical rehabilitation services (hospital based)	X	$0	
Podiatric services	X	$0	
Chiropractic services	X	$0	
Emergency Medical transportation	X	$0	
Home health care services	X	$0	
Nursing facility	X	$0	
ICF/MR	X	$0	
Hospice care	X	$0	
Private duty nursing	X	$0	
Personal care services	X	$0	Available only through home and community based services waiver
Habilitative services	X	$0	Available only through home and community based services waiver
Case management	X	$0	Limited to persons diagnosed with mental illness, children under age 3 who are receiving early intervention services, and home and community based waivers
Care coordination		$0	
Non-emergency medical transportation	X	$0	
Other (Specify): Nursing Care Services (Advanced Practice Nurses)	X	$0	
Other: Audiology	X	$0	
Other: EPSDT not otherwise listed above	X	$0	
Other: Early Intervention Services	X	$0	
Other: Optometric Services	X	$0	

[a] Cost Sharing – No copayments are required for preventive or diagnostic services in any of the categories marked above. The annual copayment maximum per family is $100. Families with children who are American Indians or Alaska Natives do not pay premiums or copayments.

3.2.2 Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))

KidCare Assist Base, KidCare Assist Expansion and KidCare Moms and Babies cover children and pregnant women through the Illinois' Medicaid Program. KidCare Share and KidCare Premium cover almost all Medicaid services provided in Illinois without limitation as displayed in Table 3.2.1. Extensive preventive services are included for KidCare Share and KidCare Premium because Illinois covers services that are available under the provisions of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program. Covered enabling services are the same as those provided under Illinois Medicaid. As a result, with Title XXI funds, Illinois is providing an exceptionally rich scope of benefits to enrolled children.

3.2.3 Delivery System

Table 3.2.3 identifies the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children.

KidCare Assist Base, KidCare Assist Expansion, KidCare Share and KidCare Premium coverage is available as fee-for-service (indemnity type) coverage or voluntary managed care. FFS has been the primary delivery system used to date. Illinois does not mandate enrollment into managed care for any of the health benefits coverage provided under KidCare.

For State fiscal year 1999, there were over 44,700 enrolled providers. This number includes more than 260 hospitals, nearly 29,000 physicians, and over 2,500 pharmacies where Illinois' KidCare enrollees may go for services.

Table 3.2.3						
Type of delivery system	**KidCare Assist Base**	**KidCare Assist Expansion**	**KidCare Moms and Babies**	**KidCare Share**	**KidCare Premium Plan**	**KidCare Rebate**
A. Comprehensive risk managed care organizations (MCOs) [a]	X	X	X	X	X	N/A
Statewide?	No	No	No	No	No	N/A
Mandatory enrollment?	No	No	No	No	No	N/A
Number of MCOs	8	8	8	5	5	N/A
B. Primary care case management (PCCM) program	Yes only for wards of the state in the child welfare system	No	No	No	No	N/A
C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)	No	No	No	No	No	N/A
D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)	Yes - All Services [b]	Yes - All Services [b]	Yes - All Services [b]	Yes - All Services [b]	Yes - All Services [b]	N/A

[a] In Illinois, the following services are excluded from the comprehensive managed care plans and are provided fee-for-service to managed care enrollees:

- Dental services, except for prescribed drugs ordered by a dentist and dental hospitalization in case of trauma;
- Vision refractions, eyeglasses, and other devices to correct vision;
- Nursing facility services beginning on the 91st day;
- Intermediate Care Facilities for the Mentally Retarded;
- Early intervention services, including case management;
- Services provided through local education agencies and school-based clinics;
- Services provided under Section 1915(c) home and community-based waivers; and
- Audiology services, physical therapy, occupational therapy and speech therapy provided to beneficiaries under 21 years of age.

[b] All services are available for participants in the fee-for-service and managed care health care delivery systems. Any services listed in note [a] above which are not covered by the MCOs, as well as family planning services, may be obtained by managed care enrollees on a fee-for-service basis. MCOs are responsible for behavioral health services, but in certain circumstances, these may also be provided FFS to managed care enrollees.

3.3 How much does SCHIP cost families?

3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance/copayments, or other out-of-pocket expenses paid by the family.)

___ No, skip to section 3.4

X___ Yes, check all that apply in Table 3.3.1

Families with children who are American Indians or Alaska Natives do not pay premiums or copayments.

Table 3.3.1

Type of cost-sharing	KidCare Assist Base, KidCare Assist Expansion, and KidCare Moms and Babies	KidCare Share	KidCare Premium	KidCare Rebate
Premiums	No	No	Yes	[a]
Enrollment fee	No	No	No	[a]
Deductibles	No	No	No	[a]
Coinsurance/copayments [b]	No	Yes	Yes	[a]

[a] Cost sharing requirements under KidCare Rebate depend on the terms of the private or employer-sponsored plan covering the child.

[b] See Table 3.2.1 for detailed information.

3.3.2 If premiums are charged: What is the level of premiums and how do they vary by program, income, family size, or other criteria? How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lock-out) before a family can re-enroll? Do you have any innovative approaches to premium collection?

Families with countable family income above 133% and at or below 150% of the FPL (KidCare Share) have no premium requirements. Families with income above 150% and at or below 185% FPL (KidCare Premium) pay monthly premiums of $15 for one child, $25 for two children or $30 for three or more children.

Families are given a 60 day grace period in which to pay a delinquent premium. If the premium is unpaid after 60 days, the family's case is canceled. Families canceled for failure to pay

premiums must wait 3 months and must pay unpaid premiums, as well as the first premium for new coverage, before coverage can begin again. Families with children who are American Indians or Alaska Natives do not pay premiums or copayments. Families can pay premium amounts over the phone by charging them to a credit card as well as by sending a check or money order.

3.3.3 **If premiums are charged:** Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))

___ Employer
_X_[a] Family
___ Absent parent
___ Private donations/sponsorship

[a] The family is billed. Any entity may pay the premium.

3.3.4 **If enrollment fee is charged:** What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria?

Not Applicable.

3.3.5 **If deductibles are charged:** What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?

Not Applicable.

3.3.6 How are families notified of their cost-sharing requirements under SCHIP, including the 5 percent cap?

Families would first become aware of the cost-sharing requirements prior to enrollment, as the application and brochure spell out these conditions.

KidCare Premium and KidCare Share families are notified of their cost sharing requirements and of Illinois' $100 annual copayment maximum at the time they are notified of their enrollment in either plan. Family copayment responsibilities are indicated on the monthly KidCare card. Families in KidCare Premium are billed monthly for premiums due. Illinois also sends a special mailing to newly enrolled families which includes a copayment tracking form to assist them.

In Illinois, the annual copayment maximum per family is $100. With or without premiums, this will never come close to 5% of family

income. For example, a one person family eligible for KidCare Premium could have countable monthly income as low as $1,031 or $12,372 a year. If this person paid $15 a month in premiums and $100 in copayments, this would equal 2.2 percent of annual income.

3.3.7 How is your SCHIP program monitoring that annual aggregate cost-sharing does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.

_X_ Shoebox method (The State gives families a form to record copayments made. They save records documenting cumulative level of cost sharing to indicate when copayments reach $100).
___ Health plan administration (health plans track cumulative level of cost sharing)
___ Audit and reconciliation (State performs audit of utilization and cost sharing)

3.3.8 What percent of families hit the 5 percent cap since your SCHIP program was implemented?

With such modest copayments and premiums, no covered Illinois family will reach the 5 percent cap.

3.3.9 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?

Illinois has not undertaken such an assessment. However, families often express the desire to share in the costs of the program. Families enrolled in KidCare Assist, which has no cost-sharing, sometimes request enrollment in other KidCare plans with low cost-sharing.

3.4 How do you reach and inform potential enrollees?

3.4.1 What client education and outreach approaches does your SCHIP program use?

Illinois has implemented a very successful, multi-pronged approach to outreach. Through a variety of strategies, Illinois, with its partners, has spread the word about KidCare, which has resulted in the enrollment of over 95,000 children and pregnant women through April 2000.

The State believes its outreach efforts to date have been very successful. In addition to persons applying at local State offices, the central KidCare enrollment unit continues to receive an average of 300 applications on a daily basis.

Illinois has been recognized by HCFA as one of several states implementing promising outreach strategies to find and enroll children in SCHIP programs. Examples of Illinois' promising practices include: a simplified application and mail-in application capability; partnering with schools to implement outreach campaigns; and collaborations with other state agencies to reach targeted families.

General outreach

- Illinois has contracted with KidCare Application Agents (KCAAs) to assist families in applying for KidCare at 1,234 locations throughout the State. KCAAs are community organizations such as hospitals, clinics, health departments, churches, insurance agents and others who tell families about KidCare and help families apply for the program. KCAAs are paid $50 for each complete application they submit that results in a new KidCare enrollment.
- Colorful and vivid brochures, applications and other materials describe KidCare as health insurance, not as welfare.
- Illinois implemented a toll-free KidCare hotline, 1-800-226-0768, that families can use to get information about the program, ask questions about the application, check on a pending application, etc. A TTY number, 1-877-204-1012, provides the same assistance.
- The Illinois Maternal & Child Health Coalition, as lead agency for the Covering Kids Illinois coalition, received a $1 million grant from the Robert Wood Johnson Foundation to assist with statewide outreach and enrollment efforts. Three pilot communities were established to mirror diverse demographic areas of Illinois: a city (Chicago/Cook County), a suburb (DuPage County) and a small city/rural area (Decatur/Macon County). KidCare has collaborated with Covering Kids on several projects including an outreach tool kit that has been distributed to over 5,000 organizations and individuals.
- Radio advertisements throughout the State have resulted in increased calls to the KidCare Hotline and increased applications.
- Television advertising on the Chicago PBS affiliate ran in the spring of 1999.
- Bus and train advertisements in the Chicago area were posted during the spring, summer and fall of 1999.

Special populations

- The State awarded $1.6 million in funding to 29 organizations to provide specialized outreach services to hard to reach populations throughout the State. During the first five months of these contracts, these community organizations have reported contacts to 117,500 people and have assisted over 1,700 families in completing the KidCare application.
- KidCare has developed outreach strategies for Hispanic families eligible for KidCare through the assistance of a public relations firm that specializes in marketing to Hispanics.
- The State plans to develop similar outreach strategies for African American families.
- Rural outreach and education strategies are being implemented for a human services organization with expertise in rural areas of the State.
- As of January 2000, children from families speaking 38 languages other than English had been enrolled.

Employers

- The State is working with an organization to assist with outreach to employers. Through collaborative efforts a newsletter was mailed to over 14,500 employers and 500 trade associations/chambers of commerce. A payroll stuffer was created, along with an outreach presentation designed to speak to employers and their employees. An Employer Guide was created to assist employers in the process of assisting their employees in the enrollment process.
- KidCare is also collaborating with another group to reach employees through their employers. An employer hotline was created and is staffed by this group to handle calls from employers needing information or wanting a presentation on the program. They also have regular meetings with local business organizations to do orientations and training sessions on the various KidCare plans.

Other Outreach Efforts

- KidCare has worked with schools and school districts throughout the State to get the word out about the program. KidCare collaborated with the State Board of Education to add a box on the application form for the national school lunch program, asking families to mark the box if they were interested in receiving further information about KidCare. Letters were sent to school districts around the State asking for their participation in outreach efforts. Presentations were given around the State to school administrators, principals, nurses,

social workers and teachers interested in learning more about KidCare and to get eligible students enrolled.

- The State is currently partnering with the Chicago Public Schools (CPS) to target KidCare outreach to children enrolled in national school lunch programs. The State and CPS are matching over 100 authorized KidCare Application Agent (KCAA) sites with specific Chicago schools to reach out to the target children and families and assist those families in applying for KidCare.
- KidCare has worked with several unions around the State to get information to their members about the plans. Several articles have been printed in various union newsletters and correspondence to members. Presentations and trainings have been provided to members and officials.

Table 3.4.1 below identifies all of the education and outreach approaches used by KidCare. Approaches used are specified and effectiveness of each approach is rated on a scale of 1 to 5
(1 = least effective and 5 = most effective).

Table 3.4.1

Approach	KidCare Assist Base, KidCare Assist Expansion, KidCare Moms and Babies		KidCare Share and KidCare Premium		KidCare Rebate	
	X = Yes	Rating (1-5)	X = Yes	Rating (1-5)	X = Yes	Rating (1-5)
Billboards						
Brochures/flyers	X	4	X	4	X	4
Direct mail by State/enrollment broker/administrative contractor	X	2	X	2	X	2
Education sessions	X	4	X	4	X	4
Home visits by State/enrollment broker/administrative contractor						
Hotline	X	4	X	4	X	4
Incentives for education/outreach staff - KCAAs	X	5	X	5	X	5
Incentives for enrollees						
Incentives for insurance agents	X	3	X	3	X	4
Non-traditional hours for application intake						
Prime-time TV advertisements	X	4	X	4	X	4
Public access cable TV	X	2	X	2	X	2
Public transportation ads	X	3	X	3	X	3
Radio/newspaper/TV advertisement and PSAs	X	4	X	4	X	4
Signs/Posters	X	2	X	2	X	2
State/broker initiated phone calls						
Other (specify) Hard to Reach – Outreach Contracts	X	4	X	4	X	2
Other (specify) Outreach to Employers Contracts	X	3	X	3	X	4

3.4.2 Where does your SCHIP program conduct education and outreach?

Table 3.4.2

Setting	Medicaid including SCHIP Expansion: KidCare Assist Base, Assist Expansion, Moms and Babies		State-Designed SCHIP Program: KidCare Share and KidCare Premium		Other State-Funded Program: KidCare Rebate	
	X = Yes	Rating (1-5)	X = Yes	Rating (1-5)	X = Yes	Rating (1-5)
Battered women shelters						
Community sponsored events	X	3	X	3	X	3
Beneficiary's home						
Day care centers	X	2	X	2	X	2
Faith communities	X	2	X	2	X	2
Fast food restaurants						
Grocery stores						
Homeless shelters						
Job training centers						
Laundromats						
Libraries	X	2	X	2	X	2
Local/community health centers	X	5	X	5	X	5
Point of service/provider locations	X	5	X	5	X	5
Public meetings/health fairs	X	4	X	4	X	4
Public housing						
Refugee resettlement programs	X	2	X	2	X	2
Schools	X	3	X	3	X	3
Senior centers						
Social service agency	X	3	X	3	X	3
Workplace	X	4	X	4	X	4

3.4.3 Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target population. Please be as specific and detailed as possible. Attach reports or other documentation where available.

The State tracks the calls received on the KidCare Hotline. The chart below demonstrates that calls received in state FY'00 related to KidCare have increased approximately 278 percent since January 1999. Hotline staff assist applicants in completing the applications, advise as to the status of the application, provide names of medical providers participating in the program and assist those determined eligible for the program with any problems they may have accessing care.

	Provider KidCare Calls	**Family KidCare Calls**
1/99	209	1,976
2/99	176	2,166
3/99	149	4,270
4/99	236	5,692
5/99	175	6,364
6/99	169	6,908
7/99	149	6,797
8/99	126	8,754
9/99	83	8,250
10/99	131	8,043
11/99	119	7,229
12/99	126	6,516
1/00	134	7,339
2/00	99	6,753

Persons calling the Hotline with KidCare questions are asked how they heard about the program. A monthly report is produced which tabulates the results (see table on next page). A review of the data over time assists in determining the effectiveness of certain approaches. For example, radio was a high volume referral source over the summer months.

KidCare Referral Sources – KidCare Hotline											
	05/99	**06/99**	**07/99**	**08/99**	**09/99**	**10/99**	**11/99**	**12/99**	**01/00**	**02/00**	**TOTAL**
RADIO	794	1,227	829	908	718	413	298	199	164	146	5,696
SCHOOLS	680	735	429	740	580	440	599	372	435	487	5,497
TV	569	662	541	700	459	247	257	146	136	175	3,892
FRIENDS & FAMILY	528	978	1,084	1,287	871	680	683	619	766	941	8,437
COMMUNITY ORG.	302	558	639	818	416	348	381	329	487	572	4,850
PROVIDERS	260	487	589	621	562	430	599	607	639	547	5,341
WORK	138	274	289	377	242	202	194	188	263	349	2,516
NEWSPAPER	125	162	152	262	133	106	118	76	74	129	1,337
OTHER	645	706	893	854	601	579	720	577	610	571	6,756
TOTALS	4,041	5,789	5,445	6,567	4,582	3,445	3,849	3,113	3,574	3,917	44,322

3.4.4 What communication approaches are being used to reach families of varying ethnic backgrounds?

Illinois has undertaken a number of strategies to reach non-English speaking families. KidCare has materials, including applications and brochures, in Spanish. Certain KidCare Hotline and KidCare Enrollment workers also speak Spanish and can discuss KidCare and answer questions over the phone. All written KidCare notices to families are available in Spanish. When a family indicates on the application that Spanish is their preferred language, written communication to them will be in Spanish.

The contractors serving hard-to-reach populations are working with families that speak a variety of languages. To date, materials have been translated into Bosnian, Chinese, Khmer, Korean, Lao, Spanish, and Vietnamese and distributed by vendors. Translations into Arabic, Polish and Russian will soon be finalized. Advertisements have been placed on Polish radio and newspapers.

Plans are being developed with two other providers to implement outreach strategies targeted specifically for Hispanic and African American families.

The State utilizes the interpretation services of a phone translation service when speaking to applicants or eligibles with limited English proficiency. The following table demonstrates the increased use of this service during six months of 1999 and the diverse languages accessed.

KidCare Hotline Translations						
	06/99	**07/99**	**08/99**	**09/99**	**10/99**	**11/99**
Arabic		10	5	1	3	2
Bosnian						1
Bulgarian					1	
Cantonese	11	5	2		6	7
French		1	1	2	2	3
Gujarati					1	
Haitian Creole						1
Hindi		1		1	1	
Japanese	1					
Korean		2		2		2
Mandarin	3	9	8	2	4	12
Polish	11	6	6	9	12	16
Portuguese		2			1	
Romanian				1		
Russian	2	2	1		3	1
Spanish	429	648	638	527	924	1078
Tagalog						2
Turkish	1	2				
Ukrainian		1				
Urdu		3			3	
Vietnamese			1	4		
TOTALS	458	702	662	549	961	1,125

3.4.5 Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.

Illinois is unable to address this question at this time. The contracts for hard-to-reach populations and other targeted outreach activities have been in existence for less than one year. The State needs additional time to accurately assess the effectiveness of these efforts.

3.5 What other health programs are available to SCHIP eligibles and how do you coordinate with them? (Section 2108(b)(1)(D))

As described previously, SCHIP is highly integrated with Medicaid in Illinois. The same state agency is responsible for administering both programs. Outreach, eligibility determination, service delivery systems, provider networks, procurement and contracting processes, data collection, quality assurance and claims processing are completely

integrated. The administration of programs varies only slightly. A few MCOs that participate in Medicaid chose not to participate in SCHIP and the benefits covered by SCHIP do not include abortion services and home and community based services available under Medicaid.

SCHIP is coordinated with Maternal and Child Health (MCH) and Women, Infants and Children (WIC) providers through outreach and service delivery. Many MCH and WIC sites have enrolled as KidCare Application Agents to take KidCare applications. MCH sites are also enrolled to provide health care.

Illinois has worked closely with school systems across the State to promote enrollment in KidCare. Most notably, the State has worked with the Chicago Public Schools to identify eligible families through the national school lunch program and assist them to apply.

The following table displays health programs with which SCHIP has a high degree of coordination.

Table 3.5

Type of coordination	Medicaid	Maternal and child health	Women, Infants and Children (WIC)	School Lunch
Administration	X			
Outreach	X	X	X	X
Eligibility determination	X			
Service delivery	X	X		
Procurement	X			
Contracting	X			
Data collection	X			
Quality assurance	X			

3.6 How do you avoid crowd-out of private insurance?

3.6.1 Describe anti-crowd-out policies implemented by your SCHIP program.

__X__ Eligibility determination process

__X__ Waiting period without health insurance (specify)

Three (3) months for KidCare Share and KidCare Premium

__X__ Information on current or previous health insurance gathered on application[a]
__X__ Information verified with employer (specify)
____ Records match (specify)
__X__ Other[b]

[a] The KidCare application requests insurance coverage information for all children and pregnant women for whom application is being made. The insurance questions are asked for all who have coverage or who have had it in the last three months.

[b] Illinois' most unique and very effective anti-crowd-out program is KidCare Rebate. Rebate is funded entirely with State dollars. Families enrolled in Rebate receive up to $75 a month per child from the State to cover private insurance premium costs for their children. With Rebate, families are encouraged to continue employer-based and other private insurance they have for their children. In fact, some families with uninsured children who would otherwise be eligible for KidCare Share or Premium choose instead to enroll their children in private insurance with the assistance of KidCare Rebate.

___ Benefit package design:

___ Benefit limits (specify)
___ Cost-sharing (specify)

3.6.2 Illinois' strategy for monitoring and experience with crowd-out.

As described above, Illinois has a unique approach to avoiding crowd-out. In the process of educating families about KidCare and in processing applications, the State's experience has been that families prefer to keep their children in available private or employer sponsored health insurance plans. By recognizing this preference and offering a rebate to offset the families' costs for this coverage, Illinois has significantly reduced the incentive for dropping private or employer-based coverage.

The KidCare application contains a question regarding insurance that must be answered for all children for whom health benefits are requested. When this information indicates that an otherwise eligible child has health insurance, the child is not denied and is enrolled in KidCare Rebate. Children cannot switch from KidCare Rebate to KidCare Share or KidCare Premium if their private or employer-sponsored health insurance was dropped voluntarily by the family.

The State will collect additional information concerning whether families are dropping private or employer-sponsored coverage to become eligible for KidCare Share or KidCare Rebate through surveys that are planned for the coming year.

SECTION 4. PROGRAM ASSESSMENT

4.1 Who enrolled in your SCHIP program?

4.1.1 What are the characteristics of children enrolled in your SCHIP program? (Section 2108(b)(1)(B)(I))

Table 4.1.1 is completed for each of Illinois' KidCare plans, based on data from the HCFA quarterly enrollment reports, as instructed by HCFA. In order to capture current data, the number of children shown are distinct users for each year rather than the sum of data from four separate quarterly reports. Average length of enrollment in Medicaid is consistent among age groups at 10 months, except of course for newborns. Now that continuous eligibility has been implemented in Illinois, children will be eligible for a full 12 months. The average length of enrollment data for KidCare Assist Expansion, KidCare Share and KidCare Premium is misleading at this point in time, as the State continues to enroll large numbers of children monthly.

Enrollment in KidCare Share and KidCare Premium has been more heavily weighted in the younger age brackets (1-5 and 6-12). Distribution of those enrolled by income level has been virtually equal between KidCare Share (134%-150% FPL) and KidCare Premium (151% - 185% FPL).

Table 4.1.1 CHIP Program Type ___KidCare Assist Base (All Medicaid)						
Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	915,334	915,179	10.00	9.82	167,460	151,808
Age						
Under 1	86,201	95,849	7.04	6.71	12,814	13,398
1-5	324,122	315,651	10.27	10.11	62,454	54,721
6-12	325,660	323,806	10.45	10.30	54,640	50,042
13-18	179,351	179,873	10.12	10.09	37,552	33,647
Countable Income Level(A)						
At or below 133% FPL	915,334	915,179	10.00	9.82	167,460	151,808
Above 133% FPL						
Age and Income						
Under 1						
At or below 133% FPL	86,201	95,849	7.04	6.71	12,814	13,398
Above 133% FPL						
1-5						
At or below 133% FPL	324,122	315,651	10.27	10.11	62,454	54,721
Above 133% FPL						
6-12						
At or below 133% FPL	325,660	323,806	10.45	10.30	54,640	50,042
Above 133% FPL						
13-18						
At or below 133% FPL	179,351	179,873	10.12	10.09	37,552	33,647
Above 133% FPL						
Type of plan						
Fee-for-service	711,887	739,283	10.47	10.26	167,440	151,802
Managed care	191,306	167,954	9.50	8.02	5	5
PCCM	12,141	7,942	8.39	7.43	15	1

Table 4.1.1 CHIP Program Type ___KidCare Assist Expansion (Medicaid Expansion / M-CHIP)_

Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	27,780	35,132	6.2	9.2	6,046	4,482
Age						
Under 1	0	0	0	0	0	0
1-5	0	0	0	0	0	0
6-12	11,681	15,731	6.0	9.0	2,617	1,746
13-18	16,099	19,401	6.5	9.4	3,429	2,736
Countable Income Level						
At or below 133% FPL	27,780	35,132	6.2	9.2	6,046	4,482
Above 133% FPL						
Age and Income						
Under 1						
At or below 133% FPL	N/A	N/A	N/A	N/A	N/A	N/A
Above 133% FPL						
1-5						
At or below 133% FPL	N/A	N/A	N/A	N/A	N/A	N/A
Above 133% FPL						
6-12						
At or below 133% FPL	11,681	15,731	6.0	9.0	2,617	1,746
Above 133% FPL						
13-18						
At or below 133% FPL	16,099	19,401	6.5	9.4	3,429	2,736
Above 133% FPL						
Type of plan						
Fee-for-service	27,132	33,683	6.3	4.9	5,942	4,480
Managed care	646	1,443	2.6	9.3	114	0
PCCM	2	6	2.0	6.5	0	0

Table 4.1.1 CHIP Program Type _ KidCare Share and KidCare Premium_(S-CHIP)_____

Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	0	7,567	0.0	4.8	0	695
Age						
Under 1	0	168	0	5.0	0	11
1-5	0	2,650	0	4.8	0	260
6-12	0	3,206	0	4.9	0	287
13-18	0	1,543	0	4.8	0	137
Countable Income Level						
134% - 150% FPL	0	3,741	0.0	5.1	0	85
151% - 185% FPL	0	3,826	0.0	4.6	0	623
Age and Income						
Under 1						
134% - 150% FPL	0	70	0.0	5.6	0	11
151% - 185% FPL	0	98	0.0	4.6	0	0
1-5						
134% - 150% FPL	0	1,303	0.0	5.0	0	37
151% - 185% FPL	0	1,347	0.0	4.6	0	227
6-12						
134% - 150% FPL	0	1,599	0.0	5.1	0	34
151% - 185% FPL	0	1,609	0.0	4.6	0	258
13-18						
134% - 150% FPL	0	771	0.0	5.2	0	14
151% - 185% FPL	0	772	0.0	4.5	0	127
Type of plan						
Fee-for-service	0	7,513	0.0	4.9	0	699
Managed care	0	54	0.0	4.2	0	0
PCCM	0	0	0.0	0.0	0	0

Table 4.1.1 CHIP Program Type KidCare Rebate (Separate State-Funded Program)

Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	0	764	0.0	3.18	0	0
Age						
Under 1	0	33	0	2.87	0	0
1-5	0	302	0	3.18	0	0
6-12	0	320	0	3.13	0	0
13-18	0	109	0	3.39	0	0
Countable Income Level						
134% - 150% FPL		363	0.0	3.21	0	0
151% - 185% FPL	0	401	0.0	3.15	0	0
Age and Income						
Under 1						
134% - 150% FPL	0	11	0.0	3.55	0	0
151% - 185% FPL	0	22	0.0	2.55	0	0
1-5						
134% - 150% FPL	0	143	0.0	3.17	0	0
151% - 185% FPL	0	159	0.0	3.21	0	0
6-12						
134% - 150% FPL	0	154	0.0	3.16	0	0
151% - 185% FPL	0	166	0.0	3.11	0	0
13-18						
134% - 150% FPL	0	55	0.0	3.44	0	0
151% - 185% FPL	0	54	0.0	3.35	0	0
Type of plan [a]	N/A	N/A	N/A	N/A	N/A	N/A

[a] Does not apply. This is a premium support program.

SOURCE: HCFA Quarterly Enrollment Reports, Forms HCFA-21E, HCFA-64.21E, HCFA-64EC, HCFA Statistical Information Management System, October 1998

4.1.2 How many SCHIP enrollees had access to or coverage by health insurance prior to enrollment in SCHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i))

About 11,000 of the 37,068 children enrolled in KidCare Assist Expansion had some amount of private health insurance prior to their enrollment in KidCare. Illinois does not have data to answer this question for children enrolled in KidCare Share or KidCare Premium except that they had no coverage for at least three months prior to enrollment.

4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C))

There are few alternative programs in the State.

4.2 Who disenrolled from your SCHIP program and why?

The numbers discussed below are extrapolated from administrative data.

4.2.1 How many children disenrolled from your SCHIP program(s)? Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected? How do SCHIP disenrollment rates compare to traditional Medicaid disenrollment rates?

Illinois expected disenrollment rates to drop some because of the high-income standards. In effect children are staying on longer. Before KidCare Assist Expansion, children either had to meet a spenddown or leave Medicaid completely once their income increased. Now they can continue coverage through a different program.

4.2.2 How many children did not re-enroll at renewal? How many of the children who did not re-enroll got other coverage when they left SCHIP?

At this time, Illinois does not have data on how many children did not re-enroll in the SCHIP program. The state is only in the early stages of the renewal process since the KidCare plans allow children 12 months of eligibility before redetermination is made. The State will continue working to report this information reliably in the future.

4.2.3 What were the reasons for discontinuation of coverage under SCHIP? (Please specify data source, methodologies, and reporting period.)

Table 4.2.3

Reason for discontinuation of coverage [a]	Medicaid including SCHIP Expansion		State-Designed SCHIP Program: KidCare Share and KidCare Premium	
	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total
Total	4,482	100%	695	100%
Access to commercial insurance		N/A	84	12%
Eligible for Medicaid [b]		N/A	[b]	N/A
Income too high	438	9.8%	87	12.5%
Aged out of program	416	9.3%	7	1.0%
Moved/died	1,142	25.5%	53	7.7%
Nonpayment of premium	0	0.0%	322	46.5%
Incomplete documentation	0	0.0%	2	0.3%
Did not reply/ unable to contact	1,536	34.3%	23	3.4%
Other Requested Cancellation	746	16.7%	112	16.1%
Other Uncooperative	2	0.03%	1	0.06%
Don't know	202	4.5%	4	.6%

[a] Data derived from a sample of disenrollees from administrative data. At the time this report was completed, disenrollee data is not available for children in KidCare Rebate.

[b] When the data was compiled, SCHIP individuals were not counted as disenrollees when moving into Medicaid, per Illinois' interpretation of HCFA's instruction on quarterly reporting. The State does know that 167 SCHIP individuals became Medicaid eligible in FFY 1999.

4.2.3 What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll?

At this point, Illinois has not detected a problem with disenrollments. These families will be included in satisfaction surveys planned for the coming months. If the surveys identify a problem, the State will devise an appropriate response.

4.3 How much did you spend on your SCHIP program?

4.3.1 What were the total expenditures for your SCHIP program in federal fiscal year (FFY) 1998 and 1999?

The numbers below reflect medical assistance spending for only the KidCare Assist Expansion plan. Through December 31, 1999, Illinois has expended over $40 million on medical services for KidCare Assist Expansion, KidCare Share, and KidCare Premium combined; however, no claims for federal reimbursement have been made to date for the KidCare Share or Premium plans. Illinois has claimed on the following total expenditures to date for the KidCare Assist Expansion plan:

FFY 1998 $9,356,392

FFY 1999 $22,662,887

Table 4.3.1 on the following page is completed for Illinois' first approved SCHIP plan (KidCare Assist Expansion) to detail expenditures by category (total computable expenditures and federal share). Spending for KidCare Share and KidCare Premium is not reflected, as no federal share has been claimed to date for these plans.

Table 4.3.1 SCHIP Program Type KidCare Assist Expansion				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures	**9,356,392**	**22,662,887**	**6,081,658**	**14,730,876**
Premiums for private health insurance (net of cost-sharing offsets) [a]	200,860	1,406,676	130,559	914,339
Fee-for-service expenditures (subtotal)	9,155,532	21,256,211	5,951,099	13,816,537
Inpatient hospital services	3,507,219	6,535,875	2,279,692	4,248,318
Inpatient mental health facility services	434,522	3,210,462	282,440	2,086,800
Nursing care services	140	20,032	91	13,021
Physician and surgical services	807,503	1,860,210	524,877	1,209,136
Outpatient hospital services	852,510	2,450,969	554,132	1,593,130
Outpatient mental health facility services	0	11,308	0	7,350
Prescribed drugs	1,221,686	2,026,811	794,095	1,317,427
Dental services	155,388	312,226	101,002	202,947
Vision services	15,265	26,689	9,923	17,348
Other practitioners' services	1,105,980	763,662	718,888	496,380
Clinic services	362,063	482,586	235,341	313,681
Therapy and rehabilitation services	4,865	10,524	3,162	6,840
Laboratory and radiological services	170,427	313,546	110,778	203,805
Durable and disposable medical equipment	95,398	155,374	62,009	100,994
Family planning [b]	0	0	0	0
Abortions	0	0	0	0
Screening services	336,146	725,425	218,495	471,526
Home health	6,600	22,045	4,290	14,330
Home and community-based services	0	0	0	0
Hospice	1,304	6,635	848	4,313
Medical transportation	54,535	407,832	35,448	265,091
Case management	15,905	39,888	10,339	25,627
Other services	8,076	1,873,743	5,618	1,218,173

[a] Expenditures reflected are based on claimed data from the HCFA 64 report.

[b] Family planning services have been claimed separately at a 90 percent federal match rate.

4.3.2 What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category.

What types of activities were funded under the 10 percent cap?

Illinois has made expenditures in two areas of activity that meet the definitions of activities eligible for federal funding under the ten percent cap. These are direct administrative expenses and outreach.

Though Illinois has expended a great deal of money and effort to reach out to families and simplify enrollment for KidCare, the State has not yet claimed any reimbursement under the Title XXI ten percent cap. The State will be able to claim federal reimbursement under SCHIP for only a portion of its administrative expenses, however, because of the restrictions of Title XXI.

In addition to the extensive and diverse outreach activities described in Section 3.4, the State has also hired approximately 200 KidCare processing and customer service staff to make prompt and consistent eligibility determinations and to respond to applicant and enrollee inquiries. Only a portion of these expenditures as well can be claimed under the 10 percent cap.

What role did the 10 percent cap have in program design?

Rather than be hindered by an arbitrary cap on expenditures, Illinois has aggressively implemented a successful outreach campaign and funded the administration costs necessary to support KidCare. Given the prescriptive administrative requirements in the federal law and proposed SCHIP regulations, the 10 percent cap is not enough to allow states to be reimbursed for the majority of both administrative and outreach related costs, especially in the early years of a new program.

Illinois is claiming all administrative costs related to the KidCare Assist Expansion under Title XIX.

Table 4.3.2 Total Expenditures Applied to the Title XXI 10 Percent Cap						
Type of expenditure	Medicaid including SCHIP Expansion: KidCare Assist Base and KidCare Assist Expansion		State-designed SCHIP Program: KidCare Share and KidCare Premium		Other State-Funded Program: KidCare Rebate	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total computable share	0	0	0	0	0	0
Outreach	0	0	0	0	0	0
Administration	0	0	0	0	0	0
Federal share	0	0	0	0	0	0
Outreach	0	0	0	0	0	0
Administration	0	0	0	0	0	0

4.3.3 What were the non-Federal sources of funds spent on your SCHIP program (Section 2108(b)(1)(B)(vii))?

_X_ State appropriations
_X_ County/local funds
___ Employer contributions
___ Foundation grants
___ Private donations (such as United Way, sponsorship)

4.4 How are you assuring SCHIP enrollees have access to care?

4.4.1 What processes are being used to monitor and evaluate access to care received by SCHIP enrollees?

For all KidCare plans, Illinois has several methods by which information about access to care is gathered. The KidCare Hotline is available to families to call when they have any questions about the program. Hotline representatives assist families in finding providers. KidCare Application Agents and KidCare's other community partners advise staff of access problems. In Illinois, Medicaid/SCHIP managed care is voluntary. More children receive health benefits through fee-for-service than managed care. This allows families more choice in choosing their providers. Illinois plans to further improve access by promoting KidCare participation with providers who are not participating.

Table 4.4.1			
Approaches to monitoring access	Medicaid including SCHIP Expansion: KidCare Assist Base, KidCare Assist Expansion, and KidCare Moms and Babies	State-designed SCHIP Program: KidCare Share and KidCare Premium	Other State-Funded Program: KidCare Rebate
Appointment audits	MCO	MCO	N/A
PCP/enrollee ratios	MCO	MCO	N/A
Time/distance standards	MCO	MCO	N/A
Urgent/routine care access standards	MCO	MCO	N/A
Network capacity reviews	MCO	MCO	N/A
Complaint/grievance/ Disenrollment reviews	FFS MCO	FFS MCO	Yes
Case file reviews (medical records review)	FFS MCO	FFS MCO	N/A
Beneficiary surveys	FFS MCO	FFS MCO	N/A
Other: Audit 24 hour telephone access	MCO	MCO	N/A

Note on Managed Care monitoring: The MCOs are required to monitor access to care for their members. Required access to care standards are delineated in the MCO contract. Additionally, a Quality Assurance Organization (QAO) provides oversight and monitoring of the MCOs' quality assurance programs.

4.4.2 What kind of managed care utilization data are you collecting for each of your SCHIP programs?

Table 4.4.2

Type of utilization data	Medicaid including SCHIP Expansion: KidCare Assist Base, KidCare Assist Expansion, and KidCare Moms and Babies	State-designed SCHIP Program: KidCare Share and KidCare Premium	Other State-Funded Program: KidCare Rebate
Requiring submission of raw encounter data by health plans	Yes	Yes	N/A
Requiring submission of aggregate HEDIS data by health plans	Yes, certain HEDIS or HEDIS-type indicators	Yes, certain HEDIS or HEDIS-type indicators	N/A
Other (specify) Behavioral Health Subcontractor Reports containing Utilization Data and Quality Assurance Monitoring information	Yes	Yes	N/A

4.4.3 What information (if any) is currently available on access to care by SCHIP enrollees in your State? Please summarize the results.

In Illinois, most enrolled families are in the fee-for-service delivery system and have freedom of choice to go to any enrolled provider. In areas of the State where it is available, the voluntary managed care delivery system allows families to choose coverage through established networks.

The State conducts an ongoing survey to determine families' satisfaction with health care programs, including KidCare Assist Base and Expansion. Data for the surveys completed between April 1998 and March 1999 revealed that the majority of participants were generally satisfied with the health care services they received. Ninety-six percent of the respondents were satisfied with the quality of services they received. Eighty-one percent were satisfied with the accessibility of medical services. Plans are under way to survey families in KidCare Share and KidCare Premium.

4.4.4 What plans does your SCHIP program have for future monitoring/evaluation of access to care by SCHIP enrollees? When will data be available?

Illinois plans to continue to monitor access to care by tracking Hotline calls from families, reviewing concerns raised by KCAAs and others, and by reviewing information gathered from ongoing KidCare satisfaction surveys. The State plans to continue to offer families assistance in finding providers and is exploring new ways to do this.

Managed Care monitoring will continue. With its external quality assurance organization, Illinois monitors managed care to ensure contractors are complying with contractual requirements related to access.

4.5 How are you measuring the quality of care received by SCHIP enrollees?

4.5.1 What processes are you using to monitor and evaluate quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, and immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3).

Fee-for-service (FFS): Illinois' ongoing Satisfaction Survey offers information on access to FFS care for KidCare Assist Base and KidCare Assist Expansion cases. For the time period of April 1998 – March 1999, these surveys revealed that the majority of families were generally satisfied with the health care services they received. An average of 96 percent of the respondents was satisfied with the quality of services they received. KidCare Share and KidCare Premium enrollees are currently not being surveyed. Surveys for KidCare Assist Base, KidCare Assist Expansion and KidCare Share and Premium cases in both FFS and managed care are planned for calendar year 2000.

Managed Care Organizations (MCOs): MCOs are required to perform an annual member satisfaction survey. For the past two years, the survey was standardized, based largely on the Consumer Assessment of Health Plans Survey (CAHPS). The aggregate analysis has not yet been performed for 1999. The aggregate results of the 1998 Member Satisfaction Survey revealed that members in managed care were generally satisfied with the services they received and with their managed care plan. A total of 1,502 surveys were completed.

- Approximately 81 percent of the respondents were completely/very satisfied or somewhat satisfied with their personal doctor.
- Approximately 76 percent of the respondents were completely/very satisfied or somewhat satisfied with their specialist.
- Approximately 71 percent of the respondents were completely/very satisfied or somewhat satisfied with their health plan.
- Approximately 96 percent of the respondents found their doctor's office to be clean and safe.
- Approximately 89 percent of the respondents who utilized inpatient hospitalization services reported satisfaction.

Table 4.5.1

Approaches to monitoring quality	Medicaid including SCHIP Expansion: KidCare Assist Base, KidCare Assist Expansion, and KidCare Moms and Babies	State-Designed SCHIP Program: KidCare Share and KidCare Premium
Focused studies (administrative and clinical required)	MCO	MCO
Participant satisfaction surveys	FFS MCO [a]	FFS MCO [a]
Complaint/grievance/ Disenrollment reviews	FFS MCO	FFS MCO
Sentinel event reviews	MCO	MCO
Plan/provider site visits	FFS MCO	FFS MCO
Case file reviews	FFS MCO	FFS MCO
Independent peer review	FFS MCO	FFS MCO
HEDIS performance measurement (note: or HEDIS-type measurement -certain measures)	MCO	MCO
Other: Credentialing	MCO	MCO
Other: Quality Assurance Plan	MCO	MCO
Other: Explanation of Medical Benefits Surveys	FFS MCO	FFS MCO

[a] Planned in Calendar Year 2000.

4.5.2 What information (if any) is currently available on quality of care received by SCHIP enrollees in your State? Please summarize the results.

The quality monitoring processes associated with Illinois' SCHIP are completely integrated with those used for Illinois' Medicaid program. This is true for managed care as well as fee-for-service.

The State's oversight of MCOs providing services to KidCare enrollees indicates that care provided satisfies community standards for quality.

The State actively monitors a range of indicators of poor quality in medical care delivered to fee-for-service enrollees. These activities include data analysis, peer review, drug utilization review and targeted inpatient reviews. The State has concluded that services delivered through the fee-for-service system also satisfy community practice standards.

4.5.3 What plans does your SCHIP program have for future monitoring/evaluation of quality of care received by SCHIP enrollees? When will data be available?

The quality monitoring processes described under 4.5.2 will continue as a permanent feature of Illinois' monitoring of KidCare Assist Base, KidCare Assist Expansion, KidCare Moms and Babies, KidCare Share and KidCare Premium.

4.5.4 Please attach any reports or other documents addressing access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance.

Available information has been detailed in the above responses.

SECTION 5. REFLECTIONS

5.1 What worked and what didn't work when designing and implementing your SCHIP program? What lessons have you learned? What are your "best practices"?

Illinois' KidCare has had a successful start. As of April 2000, 95,381 new children and pregnant women have coverage. This success is the result of: a well designed program; coordination between Medicaid and SCHIP; building KidCare around established delivery systems; extensive outreach with several diverse, effective strategies; and an emphasis on working with a variety of community partners to implement outreach and enrollment strategies.

5.1.1 Eligibility Determination/Redetermination and Enrollment

From the beginning, Illinois made integration of the Medicaid and SCHIP eligibility determination system a priority. With so many Medicaid eligibility determination restrictions, this was not a simple task. Illinois designed KidCare marketing materials, including the mail-in application, to present to families one program with five plans. These plans incorporate Medicaid, SCHIP and the State-only KidCare Rebate plan. This has been very successful.

The mail-in application has been an important part of Illinois' enrollment success. Families interact with KidCare the same way they would interact with most private insurance companies - by the phone and through the mail. Ending face-to-face interviews in State offices as the primary means of applying for health benefits was critical to encouraging working families to apply. The design of the mail-in application required staff to simplify the eligibility process by reducing the amount of information required from families. The decision to process all mail-in applications in a statewide unit dedicated only to medical eligibility determinations has allowed the State to maximize efficiency in processing.

The mail-in process has complemented the preexisting in-person Medicaid application system. State staff located in local offices in every county also take and process applications for all KidCare plans.

5.1.2 Outreach

KidCare has partnered with numerous entities, both inside and outside state government, to implement a multi-faceted outreach plan. Initiatives underway include collaborative efforts with school

districts, community-based organizations, employer groups, faith-based organizations, health care providers, local communities, and other state agencies. Illinois believes that it is critical to implement a variety of outreach strategies simultaneously, to reach large numbers of children and families.

Illinois has found its partnership with KidCare Application Agents (KCAAs) to be especially helpful. KCAAs are community organizations, such as hospitals, clinics, health departments, churches, and others who tell families about KidCare and help them apply. To properly implement this strategy, strict standards must be in place to protect the State, the KCAA and the families applying. In addition, the State has found that processing applications from KCAAs in one central unit and explaining eligibility criteria in detail to these KCAAs has simplified the tasks of training, technical assistance and ongoing operation.

Although the KidCare application is much simpler to complete, families still benefit from an explanation of the program and assistance in completing the application. Illinois learned that distributing applications is not enough. The KCAAs are important in offering the help families need to apply for the program.

Radio advertisement has been another effective outreach strategy for Illinois. According to data from calls to the KidCare Hotline, radio was a frequently cited way families learned of KidCare, during the months advertisements were running. Radio spots were a relatively inexpensive means of spreading the KidCare message.

A final reflection on outreach is that, in order to reach families, Illinois really had to spend state dollars, especially in the early stages of SCHIP implementation. The ten percent cap under Title XXI on combined administrative and outreach expenditures is prohibitive, and allowable expenditures were uncertain in a program just getting off the ground. Illinois was forced to make a decision to aggressively implement its outreach strategy without regard for eventual ability to claim under the ten percent cap.

5.1.3 Benefit Structure

Illinois' KidCare package of health benefits is very generous. Compared to nearly any other private or public health plan, KidCare covers more services with virtually no benefit limits. In developing KidCare Share and KidCare Premium, Illinois placed a high priority on comprehensive benefits. With two incidental exceptions, KidCare Share and KidCare Premium offer the same broad benefit

structure of KidCare Assist. This is one of KidCare's best selling features.

The benefit structure of KidCare Assist, Share and Premium is complemented by the flexibility, under KidCare Rebate, for families to receive help to insure their children through private or employer-sponsored plans.

In developing KidCare Rebate, federal financial participation (FFP) was an important goal - one, however, Illinois has not found a way to achieve. With federal requirements regarding benefit levels, cost sharing and employer contributions, gaining FFP for the variety of private health plans that cover Illinois children is impossible. KidCare Rebate is one of Illinois' most unique and creative strategies. Simplicity and ease of use by families is important to the plan's success.

5.1.4 Cost-Sharing (such as premiums, copayments, compliance with 5 percent cap)

Cost sharing is an important part of KidCare. As the expansion was being developed, a guiding principle was to create plans that look like private insurance. Because most private plans have cost sharing, it was agreed early that KidCare Share and KidCare Premium would have premiums and copayments, as allowed by federal law.

Illinois has not found problems with cost sharing. Modest copayments were implemented without complication, administrative or otherwise. KidCare copayments are collected by providers. The rate paid by the State is the same whether a provider collects a copayment or not. KidCare's low monthly premiums are billed and collected by the State and have not been problematic.

Federal distinctions regarding cost sharing at family income levels below and above 150% FPL forced KidCare to split the separate state program into two parts – KidCare Share and KidCare Premium. While this has not created a large number of problems, it does diminish KidCare's simplicity.

5.1.5 Delivery System

In assessing Illinois' SCHIP delivery system, it is crucial to recognize that Illinois does not mandate enrollment in managed care under any KidCare plan. Although in two urban counties in the state, families have the option of enrolling in managed care,

most families choose to participate through the fee for service system. This choice to enroll in managed care is completely voluntary and families may choose to disenroll at any time.

By using the Medicaid provider base for SCHIP, Illinois immediately had an extensive statewide network available to newly enrolling families. Using Medicaid providers also made it easy for physicians and other providers to bill for services as they did not have to learn a new billing system or relate to a different payer.

Physicians, particularly pediatricians, have supported KidCare and have provided considerable assistance to the State in educating their colleagues about KidCare. They have proven to be an excellent resource.

5.1.6 Coordination with Other Programs (especially private insurance and crowd-out)

KidCare Rebate makes KidCare well coordinated with private and employer-sponsored insurance. With Rebate, KidCare gives income eligible families support in paying for health benefits regardless of their children's insurance status.

As discussed previously, SCHIP is well coordinated with Medicaid. Although SCHIP allowed states more flexibility in program design, as compared with Medicaid, requirements that SCHIP work well with Medicaid forced Illinois to continue many Medicaid program characteristics in the SCHIP plans. Illinois encourages the Federal Government to increase Medicaid flexibility under Title XIX. Particularly in areas related to presumptive eligibility, transferring children between Medicaid and SCHIP, use of a single filing unit, the requirement that only state employees may determine Medicaid eligibility, and outstationing, flexibility is sorely needed.

5.1.7 Evaluation and Monitoring (including data reporting)

Illinois has chosen to coordinate the quality monitoring processes for SCHIP with Medicaid. As the programs themselves have been designed to be so closely linked, the State finds it efficient to also integrate monitoring efforts.

5.1.8 Other (specify)

Current federal restrictions do not allow Illinois to claim FFP and maintain the simplicity of KidCare Rebate.

5.2 What plans does your State have for "improving the availability of health insurance and health care for children"? (Section 2108(b)(1)(F))

Illinois will continue its early KidCare success by closely monitoring concerns raised by enrollees, enrollment levels, outreach strategies, policy, and procedures. Future plans include:

- Plastic swipe cards to replace monthly paper identification cards for all KidCare plans;
- Telephone enrollment;
- Innovative care coordination, including disease management initiatives;
- Enhancing physician referral by Hotline staff;
- Outreach strategies that partner with other income based programs such as School Lunch, WIC, child care, and other programs;
- Continued exploration of presumptive eligibility; and,
- Provider education initiatives.

5.3 What recommendations does your State have for improving the Title XXI program? (Section 2108(b)(1)(G))

Illinois asks that Medicaid and SCHIP flexibility be enhanced. Provisions related to the following areas should be eased:

- Presumptive eligibility;
- Use of employer based and private insurance through SCHIP;
- Family coverage;
- Copayments;
- State employees making Medicaid eligibility determinations;
- Movement of children between Title XXI and Title XIX programs;
- The single filing unit under Title XIX; and,
- The Title XXI 10 percent cap.

Illinois also suggests that waiver requests and State Plan Amendments related to SCHIP be considered on an expedited basis by HCFA.